



Operations Attachment – ACDSNB Accident Register

Belton, South Carolina

HWY20FH001

(30 pages)

within

Mail FR-10 to: SC Department of Motor Vehicles Office of Financial Responsibility (803) 896-5000 PO Box 1498, Blythewood, SC 29016				SOUTH CAROLINA DEPARTMENT OF MOTOR VEHICLES FR-10 (REV. 11/2011) NOTICE OF REQUIREMENT				Submit Electronically: Agents or Company Representatives can submit your insurance information at WWW.SC-ALIR.COM 31			
Date 05-12-2018	Time of Collision 1830	County 04	1- Interstate 2- US Primary 3- SC Primary	4- Secondary 5- County 6- PP	Collision Location (RT # / Name) N. Main St	6- Main Line 2- Alternate 5- Spur	6- Connection 7- Business	Miles: 01	Dir. N E W	In / Near City or Town of: Anderson	
<p>To Vehicle Owner/Operator</p> <p>Failure to return this form to the Department of Motor Vehicles within 15 days from the date of the collision could result in the suspension of your driver license and registration privileges pursuant to South Carolina Code of Laws 56-9-351 and 56-10-530.</p>											
J-047548			Driver/Pedestrian's Full Name Kerwin, Kenneth Leo			J-047549			Driver/Pedestrian's Full Name Anderson, Katherine Marie		
Unit # 1	Sex M	Race W	Street [REDACTED]		Unit # 2	Sex F	Race W	Street [REDACTED]			
#Occ 1	Birth Date [REDACTED]	City, State, & Zip Pendleton, SC 29670		#Occ 3	Birth Date [REDACTED]	City, State, & Zip Hobbesville, SC 29620					
State SC	Driver's License # [REDACTED]	Class D	Insurance Company: Progressive		State SC	Driver's License # [REDACTED]	Class D	Insurance Company: State Fiscal Accountability Authority			
Year 1996	Body VAN	Vehicle Make Ford	VIN # 4T3CF19C1N00 [REDACTED]		Year 2001	Body VAN	Vehicle Make Ford	VIN # 1FAPP58251A247690			
State SC	Year 2019	License Plate # [REDACTED]	Owner's DL # [REDACTED]		State SC	Year 2001	License Plate # RG18507	Owner's DL # NA			
Home Telephone [REDACTED]		Owner's Full Name Kerwin, Kenneth Leo			Home Telephone [REDACTED]		Owner's Full Name Anderson, Katherine Marie				
Bus. Telephone [REDACTED]		Street [REDACTED]			Bus. Telephone [REDACTED]		Street 212 McGee Rd				
Contributed To Collision Yes		City, State, & Zip Pendleton, SC 29670			Contributed To Collision Yes (No)		City, State, & Zip Anderson, SC 29625				
<p>J-047550 Driver/Pedestrian's Full Name</p> <p>Unit # Sex Race Street</p> <p>#Occ Birth Date City, State, & Zip</p> <p>State Driver's License # Class Insurance Company</p> <p>Year Body Vehicle Make VIN #</p> <p>State Year License Plate # Owner's DL #</p> <p>Home Telephone Owner's Full Name</p> <p>Bus. Telephone Street</p> <p>Contributed To Collision City, State, & Zip</p> <p>Yes No</p>											
<p>All Units Insurance Information (to be completed by Investigating Officer)</p> <p>Automobile liability insurance information for Unit # 1</p> <p>Company Name: Progressive Area Code/Phone Number: (804) 222-2525</p> <p>Agency Name: Progressive Policy Number: [REDACTED]</p> <p>Automobile liability insurance information for Unit # 2</p> <p>Company Name: American Southern Area Code/Phone Number: (1 800) 713-2205</p> <p>Agency Name: [REDACTED] Policy Number: [REDACTED]</p>											
<p>Automobile Liability Insurance Information</p> <p>Notice of Requirement Accepted <input checked="" type="checkbox"/> Signature _____ Y N Refused to Affix Signature?</p> <p>To Be Completed Below or Entered at WWW.SC-ALIR.COM By Insurance Company Representative</p> <p>This form should not be mailed to DMV if insurance information has been submitted electronically.</p> <p>Reference to Unit #: _____, I here by affirm that to the best of my knowledge the vehicle described above was insured by the below stated Insurance company on the date of the collision.</p> <p>Insurance Company: _____ Policy #: _____ Signature: _____ Title: _____</p> <p>Beginning Date: _____ Ending Date: _____ Policy Holder: _____ NAIC# (Assigned by S C Dept. of Ins.): _____ Bus. Telephone: _____</p> <p>Notice: If liability insurance was not in effect for your vehicle involved in the collision, The Department of Motor Vehicles could suspend your driver license and registration privileges pursuant to South Carolina Code of Laws 56-9-351 and 56-10-530.</p> <p>If any of the below are applicable, Disregard the above portion.</p> <p>Check here if a Form SR-23, Fleet policy of 25 or more vehicles is on file with the Department covering the vehicle <input type="checkbox"/></p> <p>Check here if a certificate of self-insurance has been issued by the Department covering the vehicle and indicate the certificate number: SI - _____ <input type="checkbox"/></p> <p>Check here if liability insurance was not in effect to comply with South Carolina statutory requirements. <input type="checkbox"/></p> <p>Signature: _____ Date: _____</p> <p>Form FR-10 Not Issued: Section 56-10-520</p> <p>No FR-10 Issued to Operator/ Owner of Unit #: _____</p> <p>Summons Issued to: _____</p> <p>For operating or allowing the operation of an uninsured vehicle</p> <p>Summons Number: _____</p> <p>Signature: _____</p> <p>Investigating Officer's Name: C. Francis Rank: [REDACTED] Badge #: [REDACTED] Jurisdiction Code: [REDACTED] Review Date: [REDACTED] Reviewer's Name: [REDACTED] Rank: [REDACTED] Internal Agency Code: 7015-20320</p>											

DRIVER/OWNER

15. Agency Vehicle Use at Time of Accident:

a. ☐ Route b. ☒ Other (Specify) error MA-18
Transporting two individuals for from event

16. Total Number of Consumers in vehicle: 2

Any Injuries No visible physical injuries

17. First Point of Impact (please circle appropriate letters)

F - Front

(R) - Rear

DS - Driver Side

PS - Passenger Side

18. Type of Accident:

a. ☒ Between Vehicles b. ☐ Fixed Object (complete #19) c. ☐ RR Crossing (with train) d. ☐ Overturn
e. ☐ Pedestrian f. ☐ Animal

19. Complete if Fixed Object Accident
(Enter response which caused damage):

a. ☐ Parked Vehicle b. ☐ Utility Pole c. ☐ Tree d. ☐ Culvert or Wall e. ☐ Sign f. ☐ Guardrail
g. ☐ Bridge Rail h. ☐ Fence i. ☐ Curb or Wall j. ☐ Median Barrier k. ☐ Embankment l. ☐
Other _____ (Specify)

20. Were Passengers Evacuated? a. ☐ Yes b. ☐ No

21. Were Any Passengers Secured By? a. ☐ Wheelchair b. ☐ Lapbelt c. ☐ Not Secured

22. First Person notified of accident? Vicki Worth

23. Was Pre-Trip inspection of vehicle performed by driver on date of accident? a. ☒ Yes b. ☐ No

24. Are there any actions driver feels could have prevented accident? (Explain)

Driver Signature _____

Date 8-14-18

Supervisor Signature _____

Date _____

Transportation Signature _____

Date _____

Please Complete Passenger Listing on Next Page

Passenger Listing and Their Date of Birth
(Insurance company requires this information)

1. Benjamin Karson Warner - DOB [REDACTED]
2. Matthew Knox Fennell - DOB [REDACTED]
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.

Form FR-10-13a		SC Department of Motor Vehicles Office of Financial Responsibility 803 836-5000 PO Box 1438, Blufftonwood SC 29316-0050		SOUTH CAROLINA DEPARTMENT OF MOTOR VEHICLES Form FR-10-13a REV 04-2012 NOTICE OF REQUIREMENT		Submit Electronically Agents or Company Representatives can submit your insurance information at WWW.SCAR.COM	
Date	Time	County	State	Collision Location (R#)	Name	Collision	Location
12-21-2018	1920	23	SC	85	/	2-A	1
To Vehicle Owner Operator		Failure to return this form to the Department of Motor Vehicles within 15 days from the date of the collision could result in the suspension of your driver license and registration privileges pursuant to South Carolina Code of Laws 56-9-351 and 56-10-330.					
R-531539		BASKIN		CONTESSA		SHAJUAN	
R-531540		HAMBY		TAYLOR		ELIZABETH	
Unit	Sex	Race	Street	Unit	Sex	Race	Street
01	F	B		02	F	W	
Birth Date		City, State, & Zip		Birth Date		City, State, & Zip	
1		ANDERSON SC 29625		1		SIMPSONVILLE SC 29681	
State		Driver's License #		State		Driver's License #	
SC		D		SC		D	
Year		Insurance Company		Year		Insurance Company	
2016		AMERICAN SOUTHERN INS CO		2016		ALLSTATE	
Year		Body		Year		Body	
2009		VW		2009		VW	
Year		Licenses/Plate #		Year		Licenses/Plate #	
2009		RGL723		2009		RGL723	
Year		Owner's Name		Year		Owner's Name	
2009		ANDERSON COUNTY DSNB		2009		ANDERSON COUNTY DSNB	
Year		City, State, & Zip		Year		City, State, & Zip	
2009		ANDERSON SC 29625		2009		ANDERSON SC 29625	
Year		Home Telephone		Year		Home Telephone	
2009		212 MOORE RD		2009		212 MOORE RD	
Year		Contributed To Collision		Year		Contributed To Collision	
2009		Yes		2009		Yes	
Year		City, State, & Zip		Year		City, State, & Zip	
2009		ANDERSON SC 29625		2009		ANDERSON SC 29625	
Year		Home Telephone		Year		Home Telephone	
2009		212 MOORE RD		2009		212 MOORE RD	
Year		Contributed To Collision		Year		Contributed To Collision	
2009		Yes		2009		Yes	
Year		City, State, & Zip		Year		City, State, & Zip	
2009		ANDERSON SC 29625		2009		ANDERSON SC 29625	
Year		Home Telephone		Year		Home Telephone	
2009		212 MOORE RD		2009		212 MOORE RD	
Year		Contributed To Collision		Year		Contributed To Collision	
2009		Yes		2009		Yes	
Year		City, State, & Zip		Year		City, State, & Zip	
2009		ANDERSON SC 29625		2009		ANDERSON SC 29625	
Year		Home Telephone		Year		Home Telephone	
2009		212 MOORE RD		2009		212 MOORE RD	
Year		Contributed To Collision		Year		Contributed To Collision	
2009		Yes		2009		Yes	
Year		City, State, & Zip		Year		City, State, & Zip	
2009		ANDERSON SC 29625		2009		ANDERSON SC 29625	
Year		Home Telephone		Year		Home Telephone	
2009		212 MOORE RD		2009		212 MOORE RD	
Year		Contributed To Collision		Year		Contributed To Collision	
2009		Yes		2009		Yes	
Year		City, State, & Zip		Year		City, State, & Zip	
2009		ANDERSON SC 29625		2009		ANDERSON SC 29625	
Year		Home Telephone		Year		Home Telephone	
2009		212 MOORE RD		2009		212 MOORE RD	
Year		Contributed To Collision		Year		Contributed To Collision	
2009		Yes		2009		Yes	
Year		City, State, & Zip		Year		City, State, & Zip	
2009		ANDERSON SC 29625		2009		ANDERSON SC 29625	
Year		Home Telephone		Year		Home Telephone	
2009		212 MOORE RD		2009		212 MOORE RD	
Year		Contributed To Collision		Year		Contributed To Collision	
2009		Yes		2009		Yes	
Year		City, State, & Zip		Year		City, State, & Zip	
2009		ANDERSON SC 29625		2009		ANDERSON SC 29625	
Year		Home Telephone		Year		Home Telephone	
2009		212 MOORE RD		2009		212 MOORE RD	
Year		Contributed To Collision		Year		Contributed To Collision	
2009		Yes		2009		Yes	
Year		City, State, & Zip		Year		City, State, & Zip	
2009		ANDERSON SC 29625		2009		ANDERSON SC 29625	
Year		Home Telephone		Year		Home Telephone	
2009		212 MOORE RD		2009		212 MOORE RD	
Year		Contributed To Collision		Year		Contributed To Collision	
2009		Yes		2009		Yes	
Year		City, State, & Zip		Year		City, State, & Zip	
2009		ANDERSON SC 29625		2009		ANDERSON SC 29625	
Year		Home Telephone		Year		Home Telephone	

ACDSNB

TRANSPORTATION VEHICLE ACCIDENT REPORT FORM

The information provided on this ACDSNB Transportation Vehicle Accident Report Form will be used to compile accurate, uniform, and reliable information about Agency vehicle (van, bus, small vehicle, and multi-function bus) accidents so that problems and trends may be identified and needed safety programs can be developed.

Complete and turn in this form to Transportation Dept. within two (2) business days of the accident if it involved a ACDSNB vehicle, or:

- \$2,500 or more of total property damage, or
- Personal injury (requiring treatment away from the scene), and/or fatality, to any involved vehicle occupant or pedestrian.

This form must be completed by the operator involved in the accident, or operator supervisor, and any staff passengers. **A supervisor must review and sign the completed form.** Enter only one response for each question.

Accident

Description While traveling on 85S towards Anderson
I was rear ended by another vehicle. The driver
admitted she was not paying attention and did not
notice traffic had slowed down.

1. Driver Name Contessa Baskin

2. Date of Accident 12/21/2018 3. Day of week Friday 4. Time 7:24pm
☐ AM ☐ PM

5. Vehicle Body Make Dodge 6. Bus/vehicle # 81ED

7. Vehicle Type: Small Vehicle ☐ Bus ☐ Lift Van ☐ Van ☒ Lift

8. Model Year 2011

9. Vehicle Capacity 2

10. Department Name Whitehall TTH

11. Was the Operator? a. ☐ Route Operator b. ☒ Activity Trip Operator c. ☐ OTHER

12. Operator's Age:

a. ☐ 21-30 b. ☒ 31-40 c. ☐ 41-50 d. ☐ 51-60 e. ☐ 61-70 f. ☐ 71 +

13. Operator's Experience Driving Agency Vehicle:

a. ☒ less than 1 year b. ☐ 1-4 Years c. ☐ 5-9 years d. ☐ 10-14 Years e. ☐ 15-19 Years f. ☐ 20 + Years

14. In the last 3 years, how many Agency vehicle accidents has the operator had?
(do not include this accident) 0

15. Agency Vehicle Use at Time of Accident:

a. ☐ Route b. ☒ Other (Specify)

outing with consumer

16. Total Number of Consumers in vehicle: 1

Any Injuries

None

17. First Point of Impact (please circle appropriate letters)

F - Front

R - Rear

DS - Driver Side

PS - Passenger Side

18. Type of Accident:

a. ☒ Between Vehicles b. ☐ Fixed Object (complete #19) c. ☐ RR Crossing (with train) d. ☐ Overturn
e. ☐ Pedestrian f. ☐ Animal

19. Complete if Fixed Object Accident
(enter response which caused damage):

a. ☐ Parked Vehicle b. ☐ Utility Pole c. ☐ Tree d. ☐ Culvert or Wall e. ☐ Sign f. ☐ Guardrail
g. ☐ Bridge Rail h. ☐ Fence i. ☐ Curb or Wall j. ☐ Median Barrier k. ☐ Embankment l. ☐
Other _____ (Specify)

20. Were Passengers Evacuated? a. ☐ Yes b. ☒ No

21. Were Any Passengers Secured By? a. ☐ Wheelchair b. ☒ Lapbelt c. ☐ Not Secured

22. First Person notified of accident? 911 / State Trooper

23. Was Pre-Trip inspection of vehicle performed by driver on date of accident? a. ☒ Yes b. ☐ No

24. Are there any actions driver feels could have prevented accident? (explain)
no

Driver Signature

Date

12/21/2018

Supervisor Signature

Date

Transportation Signature

Date

470

Mail FR-10 to: SC Department of Motor Vehicles Office of Financial Responsibility (803) 896-5000 PO Box 1498, Blythewood, SC 29016-0050				SOUTH CAROLINA DEPARTMENT OF MOTOR VEHICLES FR-10 (REV. 12/2018) NOTICE OF REQUIREMENT				Submit Electronically: Agents or Company Representatives can submit your Insurance Information at WWW.SC-ALIR.COM																																																																																																												
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01-10-2019	1 5 2 0	04			54 / PALMETTO RD		.18		WEST PELZER																																																																																																											
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R-516702			Driver/Pedestrian's Full Name CASSI SARAH			R-516703			Driver/Pedestrian's Full Name ALEXANDER BARRY WAYNE																																																																																																											
Unit # 01	Sex	Race	Street			Unit # 02	Sex	Race	Street																																																																																																											
#Occ 1	Birth Date	City, State, & Zip				#Occ 1	Birth Date	City, State, & Zip																																																																																																												
		FAIR PLAY SC 29643						PELZER SC 29665																																																																																																												
State SC	Driver's License #		Insurance Company		State SC	Driver's License #		Insurance Company																																																																																																												
			D STATE FISCAL ACCOUNTABILITY					DM UNINSURED																																																																																																												
Year 2017	Body BU	Vehicle Make FORD	VIN # 1FDFE4FS0HDC33470			Year 2011	Body 2S	Vehicle Make CADI	VIN # 1G6DG5EY7B0																																																																																																											
State SC	Year P	License Plate # RG1812	Owner's D.L. # NONE			State SC	Year	License Plate #	Owner's D.L. #																																																																																																											
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To Be Completed Below or Entered at WWW.SC-ALIR.COM By Insurance Company representative. This form should not be mailed to DMV if insurance information has been submitted electronically. Reference to Unit # _____ I hereby affirm that to the best of my knowledge the vehicle described above was insured by the below stated Insurance company on the date of the collision.						The information as contained herein is based solely upon my knowledge and belief as a representative of the above insurance company and no warranty of liability is imputed into the above mentioned insurance as I have listed herein.																																																																																																														
Insurance Company			Policy #			Signature			Title																																																																																																											
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Investigating Officer's Name DOOLEY - S F		Rank TFC		SCCJA # _____		Code H P 0 3		Date		Reviewer's Name																																																																																																										
										Internal Agency Code 19GV19006291																																																																																																										

ACDSNB

TRANSPORTATION VEHICLE ACCIDENT REPORT FORM

The information provided on this ACDSNB Transportation Vehicle Accident Report Form will be used to compile accurate, uniform, and reliable information about Agency vehicle (van, bus, small vehicle, and multi-function bus) accidents so that problems and trends may be identified and needed safety programs can be developed.

Complete and turn in this form to Transportation Dept. within two (2) business days of the accident if it involved a ACDSNB vehicle, or:

- > \$2,500 or more of total property damage, or
- > Personal injury (requiring treatment away from the scene), and/or fatality, to any involved vehicle occupant or pedestrian.

This form must be completed by the operator involved in the accident, or operator supervisor, and any staff passengers. **A supervisor must review and sign the completed form.** Enter only one response for each question.

Accident

Description Driving down Palmetto Street in Pelzer, SC, a silver Cadillac swerved into my lane (head on), corrected himself and clipped his mirror, knocking it off. Contact was made at left driver side of bus wear passenger/cab part of the bus begins.

1. Driver Name Cassi Fowler
2. Date of Accident Jan. 10, 2019 3. Day of week Thurs. 4. Time 3:17 PM
☐ AM ☒ PM
5. Vehicle Body Make _____ 6. Bus/vehicle # 470
7. Vehicle Type: Small Vehicle ☐ Bus ☒ Lift Van ☐ Van ☐ Lift
8. Model Year _____ 9. Vehicle Capacity _____
10. Department Name AOP/200
11. Was the Operator? a. ☒ Route Operator b. ☐ Activity Trip Operator c. ☐ OTHER
12. Operator's Age:
a. ☐ 21-30 b. ☒ 31-40 c. ☐ 41-50 d. ☐ 51-60 e. ☐ 61-70 f. ☐ 71 +
13. Operator's Experience, Driving Agency Vehicle:
a. ☐ less than 1 year b. ☒ 1-4 Years c. ☐ 5-9 years d. ☐ 10-14 Years e. ☐ 15-19 Years f. ☐ 20 + Years
14. In the last 3 years, how many Agency vehicle accidents has the operator had? (do not include this accident) 1

15. Agency Vehicle Use at Time of Accident:
a. ☒ Route b. ☐ Other (Specify) _____

16. Total Number of Consumers in vehicle: 5 Any Injuries No

17. First Point of Impact (please circle appropriate letters)
☒ F - Front ☐ R - Rear ☒ DS - Driver Side ☐ PS - Passenger Side

18. Type of Accident:
a. ☒ Between Vehicles b. ☐ Fixed Object (complete #19) c. ☐ RR Crossing (with train) d. ☐ Overturn
e. ☐ Pedestrian f. ☐ Animal

19. Complete if Fixed Object Accident
(Enter response which caused damage):
a. ☐ Parked Vehicle b. ☐ Utility Pole c. ☐ Tree d. ☐ Culvert or Wall e. ☐ Sign f. ☐ Guardrail
g. ☐ Bridge Rail h. ☐ Fence i. ☐ Curb or Wall j. ☐ Median Barrier k. ☐ Embankment l. ☐ Other _____ (Specify)

20. Were Passengers Evacuated? a. ☐ Yes b. ☒ No

21. Were Any Passengers Secured By? a. ☒ Wheelchair b. ☒ Lapbelt c. ☐ Not Secured

22. First Person notified of accident? Terri Abernathy

23. Was Pre-Trip inspection of vehicle performed by driver on date of accident? a. ☒ Yes b. ☐ No

24. Are there any actions driver feels could have prevented accident? (Explain)
Driver was hit by vehicle in oncoming lane - No.

Driver Signature _____

Date 1/15/20

Supervisor Signature _____

Date _____

Transportation Signature _____

Date _____

Please Complete Passenger Listing on Next Page

Passenger Listing and Their Date of Birth
(Insurance company requires this information)

1. Jean Harmon [REDACTED]
2. Faye McAlister [REDACTED]
3. Michelle Hutchinson [REDACTED]
4. Robert Evan Shord [REDACTED]
5. Walker Clardy. [REDACTED]
6. [REDACTED]
- 7.
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.

Mail FR-10 to: SC Department of Motor Vehicles Office of Financial Responsibility (803) 896-5000 PO Box 1498, Blythewood, SC 29016-0050				SOUTH CAROLINA DEPARTMENT OF MOTOR VEHICLES FR-10 (REV. 02/2019) NOTICE OF REQUIREMENT				Submit Electronically: Agents or Company Representatives can submit your Insurance Information at WWW.SC-ALIR.COM							
Date 12-17-2019	Time 1 5 3 5	County 04	1 - Interstate 4 - Secondary 2 - US Primary 5 - County 3 - SC Primary 6 - PP		Collision Location (RL # / Name) 676 / BELTON HONEA PATH		0 - Main Line 6 - Connection 2 - Alternate 7 - Business 5 - Spur		Miles .70	Dir. N (E) S W	In (Near) City or Town of BELTON				
To Vehicle Owner/Operator: Failure to return this form to the Department of Motor Vehicles within 15 days from the date of the collision could result in the suspension of your driver license and registration privileges pursuant to South Carolina Code of Laws 56-9-351 and 56-10-530.															
R-866903				Driver/Pedestrian's Full Name RAMSEY TAYLOR BROOKE				R-866942				Driver/Pedestrian's Full Name DEPETRILLO SHERRI T			
Unit # 01	Sex [redacted]	Race [redacted]	Street [redacted]		Unit # 02		Sex [redacted]	Race [redacted]	Street [redacted]						
#Occ 8	Birth Date [redacted]		City, State, & Zip ANDERSON SC 29621		#Occ 1		Birth Date [redacted]		City, State, & Zip BELTON SC 29627						
State SC	Driver's License # [redacted]		Insurance Company D AMERICAN SOUTHERN		State SC		Driver's License # [redacted]		Insurance Company D PROGRESSIVE						
Year 2 0 0 9	Body BU	Vehicle Make FORD	VIN # 1FDEE35L99DA23497		Year 2 0 1 5		Body SU	Vehicle Make CHEV	VIN # 2GNALBEK5F [redacted]						
State SC	Year P	License Plate # RG1203	Owner's D.L. # NONE		State SC		Year 2 0 2 0	License Plate # [redacted]	Owner's D.L. # [redacted]						
Home Telephone [redacted]		Owner's Full Name ANDERSON COUNTY DISABILITIES				Home Telephone [redacted]		Owner's Full Name DEPETRILLO SHERRI T							
Bus. Telephone [redacted]		Street 212 MCGEE RD				Bus. Telephone [redacted]		Street [redacted]							
Contributed To Collision Yes <input type="radio"/> No <input checked="" type="radio"/>		City, State, & Zip ANDERSON SC 29625				Contributed To Collision Yes <input checked="" type="radio"/> No <input type="radio"/>		City, State, & Zip BELTON SC 29627							
Driver/Pedestrian's Full Name															
State Year License Plate # Owner's D.L. #															
Unit # [redacted]	Sex [redacted]	Race [redacted]	Street [redacted]		Home Telephone [redacted]		Owner's Full Name [redacted]								
#Occ [redacted]	Birth Date [redacted]		City, State, & Zip [redacted]		Bus. Telephone [redacted]		Street [redacted]								
State [redacted]	Driver's License # [redacted]		Insurance Company [redacted]		Contributed To Collision Yes <input type="radio"/> No <input type="radio"/>		City, State, & Zip [redacted]								
Year [redacted]	Body [redacted]	Vehicle Make [redacted]	VIN # [redacted]		Accident Insurance Information for Unit # 02										
All Units Insurance Information (to be completed by Investigating Officer)															
Accident Insurance Information for Unit # 01 Company Name: AMERICAN SOUTHERN Area Code/Phone Number: () Agency Name: Policy Number: [redacted]															
Accident Insurance Information for Unit # Company Name: Area Code/Phone Number: () Agency Name: Policy Number: [redacted]															
Automobile Liability Insurance Information															
Notice of Requirement Accepted <input checked="" type="checkbox"/> Signature: _____										Y N Refused to Affix Signature? Y N Vehicle Subject to Registration in SC?					
To Be Completed Below or Entered at WWW.SC-ALIR.COM By Insurance Company representative. This form should not be mailed to DMV if insurance information has been submitted electronically. Reference to Unit # _____. I hereby affirm that to the best of my knowledge the vehicle described above was insured by the below stated Insurance company on the date of the collision.															
Insurance Company				Policy #				Signature		Title					
Beginning Date		Ending Date		Policy Holder				NAIC# (Assigned by S.C. Dept. of Ins.)		Bus. Telephone ()					
Notice: If liability insurance was not in effect for your vehicle involved in the collision, the Department of Motor Vehicles could suspend your driver license and registration privileges pursuant to South Carolina Code of Laws 56-9-351 and 56-10-530.															
If any of the below are applicable, Disregard the above portion.										Form FR-10 Not Issued: Section 56-10-520					
Check here if a Form SR-23 Fleet policy of 25 or more vehicles is on file with the Department of Motor Vehicles covering the vehicle Check here if a certificate of self-insurance has been issued by the Department of Motor Vehicles covering the vehicle and indicate the certificate number: SI - _____ Check here if liability insurance was not in effect to comply with South Carolina statutory requirements										No FR-10 Issued to Operator/ Owner of Unit # _____ Summons Issued to: _____ For operating or allowing the operation of an uninsured vehicle Summons Number _____ Signature _____					
Investigating Officer's Name ASHLEY - A T				Rank L/CPL		SCCJA # 2081-7837		Code H P 0 3		Date					
Reviewer's Name				Rank		Internal Agency Code 19GV234191									

ACDSNB

TRANSPORTATION VEHICLE ACCIDENT REPORT FORM

The information provided on this ACDSNB Transportation Vehicle Accident Report Form will be used to compile accurate, uniform, and reliable information about Agency vehicle (van, bus, small vehicle, and multi-function bus) accidents so that problems and trends may be identified and needed safety programs can be developed.

Complete and turn in this form to Transportation Dept. within two (2) business days of the accident if it involved a ACDSNB vehicle, or:

- > \$2,500 or more of total property damage, or
- > Personal injury (requiring treatment away from the scene), and/or fatality, to any involved vehicle occupant or pedestrian.

This form must be completed by the operator involved in the accident, or operator supervisor, and any staff passengers. **A supervisor must review and sign the completed form.** Enter only one response for each question.

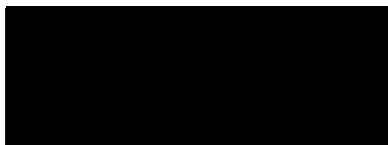
Accident

Description: While waiting at a red light on the intersection of Whitehall Road and Clemson Blvd (W/O on right hand side) a Toyota Mini Van rear ended the agency Ford wagon.

1. Driver Name Katharine Marie Arseneau
2. Date of Accident 5/12/18
☐ AM ☐ PM
3. Day of week Saturday
4. Time 6:15
5. Vehicle Body Make _____
6. Bus/vehicle # _____
7. Vehicle Type: Small Vehicle ☒ Bus ☐ Lift Van ☐ Van ☐ Lift ☐
8. Model Year _____
9. Vehicle Capacity _____
10. Department Name _____
11. Was the Operator? a. ☐ Route Operator b. ☐ Activity Trip Operator c. ☐ OTHER
12. Operator's Age: a. ☐ 21-30 b. ☐ 31-40 c. ☐ 41-50 d. ☒ 51-60 e. ☐ 61-70 f. ☐ 71 +
13. Operator's Experience Driving Agency Vehicle: a. ☐ less than 1 year b. ☒ 1-4 Years c. ☐ 5-9 years d. ☐ 10-14 Years e. ☐ 15-19 Years f. ☐ 20 + Years
14. In the last 3 years, how many Agency vehicle accidents has the operator had? (do not include this accident) 1

Mail: FR-10 to _____ SC Department of Motor Vehicles Office of Financial Responsibility (803) 896-5000 PO Box 1498, Sylvanwood, SC 29616-0050			SOUTH CAROLINA DEPARTMENT OF MOTOR VEHICLES FR-10 (REV. 11-2011) NOTICE OF REQUIREMENT			Submit Electronically... Agents or Company Representatives can submit your Insurance Information at WWW.SC-ALIR.COM		
Date 11-17-2015	Time 1500	County 04	Secondary 1-Interstate 2-US Primary 3-SC Primary 4-PP	Collision Location (Rt # / Name) 141 / S MCDOUFFIE ST	2-Alternate 3-Source	Miles .74	Dir. N E S W	In (Near) City or Town of ANDERSON
To Vehicle Owner/ Operator	Failure to return this form to the Department of Motor Vehicles within 15 days from the date of the collision could result in the suspension of your driver license and registration privileges pursuant to South Carolina Code of Laws 56-9-351 and 56-10-530.							
M-114479			Driver/Pedestrian's Full Name DODGE PHILIP MICHAEL			M-114684		
Unit # 01	Sex M	Race W	Street [REDACTED]	Unit # 02	Sex F	Race B	Street [REDACTED]	Driver/Pedestrian's Full Name HOLDEN BARBARA JEAN
Acc # 1	Birth Date [REDACTED]		City, State, & Zip ANDERSON SC 29621	Acc # 1	Birth Date [REDACTED]		City, State, & Zip SENECA SC 29678	
State SC	Driver's License # [REDACTED]		Insurance Company ALLSTATE	State SC	Driver's License # [REDACTED]		Insurance Company SC BUDGET AND CONTROL	
Year 1999	Body TK	Vehicle Make FORD	VIN # 1FTSX30F0XEE [REDACTED]	Year 2016	Body BU	Vehicle Make FORD	VIN # 1F0EE3FL8GDC03548	
State SC	Year 2016	License Plate # [REDACTED]	Owner's D.L. # [REDACTED]	State SC	Year 2009	License Plate # RG1581	Owner's D.L. # NONE	
Home Telephone [REDACTED]		Owner's Full Name DODGE PHILIP MICHAEL		Home Telephone [REDACTED]		Owner's Full Name ANDERSON COUNTY DISABILITIES A		
Bus. Telephone ()		Street [REDACTED]		Bus. Telephone ()		Street 212 MCGEE RD		
Contributed To Collision Yes		City, State, & Zip ANDERSON SC 29621		Contributed To Collision Yes		City, State, & Zip ANDERSON SC 29621		
Driver/Pedestrian's Full Name				State		Year		License Plate #
Unit # Sex Race Street				Home Telephone		Owner's Full Name		
Acc # Birth Date City, State, & Zip				Bus. Telephone		Street		
State Driver's License # Insurance Company				Contributed To Collision Yes No		City, State, & Zip		
Year Body Vehicle Make VIN #				Accident Insurance Information for Unit # 02				
All Units Insurance Information (to be completed by Investigating Officer)				Company Name SC BUDGET AND CONTROL		Area Code/Phone Number (800) 7132205		
Accident Insurance Information for Unit # 01				Agency Name		Policy Number		
Company Name ALLSTATE				Area Code/Phone Number (803) 6480767		Accident Insurance Information for Unit #		
Agency Name ANDREW SIDERS				Policy Number		Company Name		
				Area Code/Phone Number		Agency Name		
				Policy Number				
Automobile Liability Insurance Information								
Notice of Requirement Accepted				Signature				
To Be Completed Below or Entered at WWW.SC-ALIR.COM by Insurance Company representative. This form should not be mailed to DMV if insurance information has been submitted electronically				Y/N Refused to Affix Signature?				
Reference to Unit #: _____ I here by affirm that to the best of my knowledge the vehicle described above was insured by the below stated insurance company on the date of the collision.				Y/N Vehicle Subject to Registration in SC?				
Insurance Company				Policy #		Signature		
Beginning Date				Ending Date		Title		
Policy Holder				Name (As given to SC Dept of Ins.)		Bus. Telephone		
Notice: If liability insurance was not in effect for your vehicle involved in the collision, the Department of Motor Vehicles could suspend your driver license and registration privileges pursuant to South Carolina Code of Laws 56-9-351 and 56-10-530.								
If any of the below are applicable, Disregard the above portion.				Form FR-10 Not Issued: Section 56-10-520				
Check Here if a Form SR-25, Fleet policy of 25 or more vehicles is on file with the Department of Motor Vehicles covering the vehicle				Has FR-10 Issued to Operator/Owner of Unit #				
Check Here if a certificate of self-insurance has been issued by the Department of Motor Vehicles covering the vehicle and indicate the certificate number SL-_____				Summons Issued to:				
Check Here if liability insurance was not in effect to comply with South Carolina statutory requirements				Signature		Summons Number		
Investigating Officer's Name WILSON - T D				Rank L/CPL		Badge # T368		Code HP03
Date				Signature		Internal Agency Code 15GV228186		

Claim #



ACDSNB

TRANSPORTATION VEHICLE ACCIDENT REPORT FORM

The information provided on this ACDSNB Transportation Vehicle Accident Report Form will be used to compile accurate, uniform, and reliable information about Agency vehicle (van, bus, small vehicle, and multi-function bus) accidents so that problems and trends may be identified and needed safety programs can be developed.

Complete and turn in this form to Transportation Dept. within two (2) business days of the accident if it involved a ACDSNB vehicle, or:

- \$2,500 or more of total property damage, or
- Personal injury (requiring treatment away from the scene), and/or fatality, to any involved vehicle occupant or pedestrian.

This form must be completed by the operator involved in the accident, or operator supervisor, and any staff passengers. **A supervisor must review and sign the completed form.** Enter only one response for each question.

Accident

Description Driving from Electrolux site on George Albert Lake Rd. The bus hit side mirror of another car.

1. Driver Name Barbara Holden

2. Date of Accident 11/17/2015 3. Day of week Tuesday 4. Time 2:50 p.m.

☐ AM ☒ PM

5. Vehicle Body Make _____ 6. Bus/vehicle # _____

7. Vehicle Type: Small Vehicle ☐ Bus ☒ Lift Van ☐ Van ☐ Lift Bus ☐

8. Model Year _____ 9. Vehicle Capacity _____

10. Department Name Anderson DSN Board

11. Was the Operator? a. ☒ Route Operator b. ☐ Activity Trip Operator c. ☐ OTHER

12. Operator's Age:

a. ☐ 21-30 b. ☐ 31-40 c. ☐ 41-50 ☒ 51-60 e. ☐ 61-70 f. ☐ 71 +

13. Operator's Experience Driving Agency Vehicle:

a. ☐ less than 1 year b. ☐ 1-4 Years c. ☐ 5-9 years ☐ d. ☒ 10-14 Years e. ☐ 15-19 Years f. ☐ 20 + Years

14. In the last 3 years, how many Agency vehicle accidents has the operator had? (do not include this accident) 0

15. Agency Vehicle Use at Time of Accident:
a. ☒ Route b. ☐ Other (Specify)

16. Total Number of Consumers in vehicle: 5 Any Injuries none

17. First Point of Impact (please circle appropriate letters)
F - Front R - Rear DS Driver Side PS - Passenger Side

18. Type of Accident:
a. ☒ Between Vehicles b. ☐ Fixed Object (complete #19) c. ☐ RR Crossing (with train) d. ☐ Overturn
e. ☐ Pedestrian f. ☐ Animal

19. Complete if Fixed Object Accident
(enter response which caused damage):
a. ☐ Parked Vehicle b. ☐ Utility Pole c. ☐ Tree d. ☐ Culvert or Wall e. ☐ Sign f. ☐ Guardrail
g. ☐ Bridge Rail h. ☐ Fence i. ☐ Curb or Wall j. ☐ Median Barrier k. ☐ Embankment l. ☐
Other _____ (Specify)

20. Were Passengers Evacuated? a. ☐ Yes b. ☒ No

21. Were Any Passengers Secured By? a. ☐ Wheelchair b. ☒ Lapbelt c. ☐ Not Secured

22. First Person notified of accident? Marshall

23. Was Pre-Trip inspection of vehicle performed by driver on date of accident? a. ☒ Yes b. ☐ No

24. Are there any actions driver feels could have prevented accident? (explain)
Drive closer to edge of the road.

Driver Signature _____

Date 11/17/15

Supervisor Signature _____

Date _____

Transportation Signature _____

Date _____

Mail FR-10 to: SC Department of Motor Vehicles
Office of Financial Responsibility (803) 896-5000
PO Box 1498, Blythewood, SC 29016

SOUTH CAROLINA DEPARTMENT OF MOTOR VEHICLES
FR-10 (REV. 11/2011)
NOTICE OF REQUIREMENT

Submit Electronically: Agents or Company
Representatives can submit your insurance
information at WWW.SC-ALIR.COM

Date 12/17/2015	Time of Collision 0750	County Col	1- Interstate 2- US Primary 3- SC Primary	4- Secondary 5- County 6- PP	Collision Location (Rt. # / Name) 5 / Highway 161	0- Main Line 2- Alternate 5- Spur	6- Connection 7- Business	Miles: Dir. N E S W In Near City, or Town of: Anderson
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To Vehicle
Owner/
Operator

Failure to return this form to the Department of Motor Vehicles within 15 days from the date of the collision could result in the suspension of your driver license and registration privileges pursuant to South Carolina Code of Laws 56-9-351 and 56-10-530.

D-576603 Driver/Pedestrian's Full Name Slump-Kenneth R. Brown				D-576604 Driver/Pedestrian's Full Name Dennis Redneck Sprake			
Unit # 1	Sex M	Race B	Street [REDACTED]	Unit # 9	Sex M	Race B	Street [REDACTED]
#Occ 3	Birth Date [REDACTED]	City, State, & Zip Anderson SC 29626		#Occ 1	Birth Date [REDACTED]	City, State, & Zip Rothwell SC 29677	
State SC	Driver's License # [REDACTED]	Class D	Insurance Company: SC Budget & Central	State SC	Driver's License # [REDACTED]	Class D	Insurance Company: R. [REDACTED]
Year 2006	Body Van	Vehicle Make Ford	VIN # 1D14P25F460719774	Year 2007	Body Van	Vehicle Make Ford	VIN # 1F07J467E244[REDACTED]
State SC	Year 2006	License Plate # 176-24573	Owner's D.L. # N/A	State SC	Year 2006	License Plate # [REDACTED]	Owner's D.L. # [REDACTED]
Home Telephone [REDACTED]		Owner's Full Name Anderson County DMV		Home Telephone [REDACTED]		Owner's Full Name [REDACTED]	
Bus. Telephone ()		Street 212 McGee Rd		Bus. Telephone ()		Street [REDACTED]	
Contributed To Collision Yes		City, State, & Zip Anderson SC 29606		Contributed To Collision Yes		City, State, & Zip [REDACTED]	

D-576605 Driver/Pedestrian's Full Name				State	Year	License Plate #	Owner's D.L. #
Unit # N/A	Sex	Race	Street	Home Telephone ()		Owner's Full Name	
#Occ	Birth Date	City, State, & Zip		Bus. Telephone ()		Street	
State	Driver's License #	Class	Insurance Company:	Contributed To Collision Yes No		City, State, & Zip	
Year	Body	Vehicle Make	VIN #	Automobile liability insurance information for Unit # 1			
All Units Insurance Information (to be completed by Investigating Officer)				Company Name S.C. Budget & Central Blvd		Area Code/Phone Number (1800) 713-3209	
				Agency Name N/A		Policy Number [REDACTED]	
Automobile liability insurance information for Unit #				Automobile liability insurance information for Unit # 2			
Company Name		Area Code/Phone Number ()		Company Name Bristol West Ins Company		Area Code/Phone Number (314) 408-9253	
Agency Name		Policy Number		Agency Name One Stop Quotes		Policy Number [REDACTED]	

Automobile Liability Insurance Information

Notice of Requirement Accepted		Signature		Y N Refused to Affix Signature?	
				Y N Vehicle Subject to Registration in SC?	
To Be Completed Below or Entered at WWW.SC-ALIR.COM By Insurance Company Representative. This form should not be mailed to DMV if insurance information has been submitted electronically. Reference to Unit #: _____, I here by affirm that to the best of my knowledge the vehicle described above was insured by the below stated Insurance company on the date of the collision.				The information as contained herein is based solely upon my knowledge and belief as a representative of the above insurance company and no warranty of liability is imputed into the above mentioned insurance as I have listed herein	
Insurance Company		Policy #:		Signature	
Beginning Date:		Ending Date:		Title	
Policy Holder:		NAIC# (Assigned by S.C. Dept. of Ins.)		Bus. Telephone ()	

Notice: If liability insurance was not in effect for your vehicle involved in the collision, The Department of Motor Vehicles could suspend your driver license and registration privileges pursuant to South Carolina Code of Laws 56-9-351 and 56-10-530.

If any of the below are applicable, Disregard the above portion.

Form FR-10 Not Issued: Section 56-10-520

<input type="checkbox"/> Check here if a Form SR-23, Fleet policy of 25 or more vehicles is on file with the Department covering the vehicle	Signature	Date
<input type="checkbox"/> Check here if a certificate of self-insurance has been issued by the Department covering the vehicle and indicate the certificate number: SI - _____		
<input type="checkbox"/> Check here if liability insurance was not in effect to comply with South Carolina statutory requirements.		

No FR-10 Issued to Operator/ Owner of Unit #: _____
Summons Issued to:

For operating or allowing the operation of an uninsured vehicle

Summons Number:

Signature

Investigating Officer's Name D. [REDACTED]	Rank [REDACTED]	Badge # [REDACTED]	Jurisdiction Code [REDACTED]	Review Date [REDACTED]	Reviewer's Name [REDACTED]	Rank [REDACTED]	Internal Agency Code [REDACTED]
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DRIVER/OWNER

Claim #

ACDSNB

TRANSPORTATION VEHICLE ACCIDENT REPORT FORM

The information provided on this ACDSNB Transportation Vehicle Accident Report Form will be used to compile accurate, uniform, and reliable information about Agency vehicle (van, bus, small vehicle, and multi-function bus) accidents so that problems and trends may be identified and needed safety programs can be developed.

Complete and turn in this form to Transportation Dept. within two (2) business days of the accident if it involved a ACDSNB vehicle, or:

- > \$2,500 or more of total property damage, or
- > Personal injury (requiring treatment away from the scene), and/or fatality, to any involved vehicle occupant or pedestrian.

This form must be completed by the operator involved in the accident, or operator supervisor, and any staff passengers. **A supervisor must review and sign the completed form.** Enter only one response for each question.

Accident

Description I was stopped at a stop sign before I signaled to turn left on the main road, and double checked each direction because the rain was heavy. Then I turned left but then immediately tried to stop my vehicle because the vehicle in front of me had slammed on brakes.

1. Driver Name Hendrick Sloan

2. Date of Accident 12/17/15 3. Day of week Thursday 4. Time 7:54A
☒ AM ☐ PM

5. Vehicle Body Make Dodge 6. Bus/vehicle # _____

7. Vehicle Type: Small Vehicle ☐ Bus ☐ Lift Van ☐ Van ☒ Lift Bus ☐

8. Model Year _____ 9. Vehicle Capacity _____

10. Department Name Res. services (SUP)

11. Was the Operator? a. ☐ Route Operator b. ☐ Activity Trip Operator c. ☒ OTHER

12. Operator's Age:

a. ☒ 21-30 b. ☐ 31-40 c. ☐ 41-50 d. ☐ 51-60 e. ☐ 61-70 f. ☐ 71 +

13. Operator's Experience Driving Agency Vehicle:

a. ☐ less than 1 year b. ☒ 1-4 Years c. ☐ 5-9 years d. ☐ 10-14 Years e. ☐ 15-19 Years f. ☐ 20 + Years

14. In the last 3 years, how many Agency vehicle accidents has the operator had? (do not include this accident) none

15. Agency Vehicle Use at Time of Accident:

a. ☐ Route b. ☒ Other (Specify)
Work and medical appointments

16. Total Number of Consumers in vehicle: 2 Any Injuries 1

17. First Point of Impact (please circle appropriate letters)

☒ F - Front R - Rear DS - Driver Side PS - Passenger Side

18. Type of Accident:

a. ☒ Between Vehicles b. ☐ Fixed Object (complete #19) c. ☐ RR Crossing (with train) d. ☐ Overturn
e. ☐ Pedestrian f. ☐ Animal

19. Complete if Fixed Object Accident
(enter response which caused damage):

a. ☐ Parked Vehicle b. ☐ Utility Pole c. ☐ Tree d. ☐ Culvert or Wall e. ☐ Sign f. ☐ Guardrail
g. ☐ Bridge Rail h. ☐ Fence i. ☐ Curb or Wall j. ☐ Median Barrier k. ☐ Embankment l. ☐
Other _____ (Specify)

20. Were Passengers Evacuated? a. ☐ Yes b. ☒ No

21. Were Any Passengers Secured By? a. ☐ Wheelchair b. ☐ Lapbelt c. ☐ Not Secured

22. First Person notified of accident? Vickie Worth

23. Was Pre-Trip inspection of vehicle performed by driver on date of accident? a. ☒ Yes b. ☐ No

24. Are there any actions driver feels could have prevented accident? (explain)

I could have took a different route.

Driver Signature [Redacted]

Date 12/17/15

Supervisor Signature Melissa Gunner

Date 12/17/15

Transportation Signature _____

Date _____

Form S-438
Rev. 06/2014

UNIFORM TRAFFIC TICKET

STATE OF SOUTH CAROLINA
VERSUS

FIRST NAME Kendrick MIDDLE NAME Reamon LAST NAME Steen

STREET [REDACTED] CITY Anderson STATE SC ZIP CODE 29624

DL STATE SC DRIVER'S LICENSE NO. [REDACTED] CLASS D ☐ YES ☒ NO

RACE B SEX M BIRTH DATE [REDACTED] HGT. 5'8 WGT. 170 HAIR Blk EYES Brn

VEH. LIC. NO. R620533 STATE SC MAKE OF VEH. Dodge YEAR 06 HAZ. MAT. NO BIPOLE NO COMB. NO OTHER NO

VEHICLE OWNER FIRST NAME Anderson MIDDLE NAME County LAST NAME DSNB STATE SC ZIP CODE 29695

OWNER STREET 219 McCall Rd CITY Anderson STATE SC ZIP CODE 29695

YOU ARE SUMMONED TO APPEAR BEFORE THE TRIAL COURT
NAME OF TRIAL COURT Municipal STREET Hol S Main St CITY Anderson STATE SC ZIP CODE 29694

DATE OF TRIAL 02/02/16 TIME OF TRIAL 0900 VIOLATION - COURT APPEARANCE REQUIRED YES ☒ NO ☐

VIOLATION SECTION NO. 32-81 TIME OF VIOL. 0754 SC POINTS 0 B.A. LEVEL 0

DATE OF VIOLATION 12/17/15 VIOLATION LOCATION Williamston Rd / Hwy 29 CITY Anderson

LAT [REDACTED] LONG [REDACTED] SCCJA OFFICER NUMBER [REDACTED]

NAME AND RANK OF ARRESTING OFFICER D. Morgan BOND AMOUNT REQUESTED \$13.75

BAIL DEPOSITED C/S DATE OF ARREST 12/17/15

PRESENT THIS SUMMONS TO THE TRIAL COURT SHOWN ABOVE
BE SURE YOU UNDERSTAND FROM THE ARRESTING OFFICER THE EXACT TIME AND BEFORE WHOM YOU ARE TO APPEAR. IF THIS TICKET IS WRITTEN FOR A TRAFFIC VIOLATION AND YOU FORFEIT BAIL, PLEAD GUILTY OR NOLO CONTENDERE, OR ARE CONVICTED AFTER A TRIAL, THIS VIOLATION WILL BE PLACED AGAINST YOUR DRIVING RECORD, OR FORWARDED TO YOUR HOME STATE. POINTS FOR OUT OF STATE VIOLATOR WILL BE ASSESSED BY YOUR HOME STATE LICENSING AUTHORITY AND MAY DIFFER FROM STATE TO STATE. FAILURE TO COMPLY WITH THE TERMS OF THIS SUMMONS MAY RESULT IN THE SUSPENSION OF YOUR DRIVER'S LICENSE BY YOUR HOME STATE. YOU ARE REQUIRED BY LAW TO APPEAR IN COURT FOR CERTAIN OFFENSES.

SEE IMPORTANT INFORMATION ON THE REVERSE SIDE OF THIS TICKET.

VIOLATOR'S COPY TICKET# [REDACTED]

Mail FR-10 to: SC Department of Motor Vehicles
Office of Financial Responsibility (803) 896-5000
PO Box 1498, Blithewood, SC 29016-0050

SOUTH CAROLINA DEPARTMENT OF MOTOR VEHICLES FR-10 (REV. 11/2011)
NOTICE OF REQUIREMENT

Submit Electronically: Agents or Company
Representatives can submit your Insurance
Information at WWW.SC-ALIR.COM

Date: 03-14-2016 Time: 10:55 County: 04 1-Interstate 4-Secondary 2-US Primary 5-County 3-SC Primary 6-PP Collision Location (Rt. # / Name): 81 / HIGHWAY 81 N 1-Main line 6-Connector 2-Alternate 7-Business 5-Spur Miles: 5.73 Dir: N E S W In (Near) City or Town of: WILLIAMSTON

To Vehicle
Owner/
Operator

Failure to return this form to the Department of Motor Vehicles within 15 days from the date of the collision could result in the suspension of your driver license and registration privileges pursuant to South Carolina Code of Laws 56-9-351 and 56-10-530.

M-128109

Driver/Pedestrian's Full Name

JENKINS JESSICA LASHEA

Unit # 01 Sex F Race B Street [REDACTED]
Birth Date [REDACTED] City, State, & Zip CENTRAL SC 29630
State SC Driver's License # [REDACTED] Insurance Company: SC BUDGET & CONTROL
Year 2007 Body VN Vehicle Make CHRY VIN # 3A4FY58BX7T620447
State SC Year P License Plate # RG1704 Owner's D.L. # NONE
Home Telephone [REDACTED] Owner's Full Name ANDERSON COUNTY OSNB
Bus. Telephone [REDACTED] Street 212 MCGEE RD
Contributed To Collision City, State, & Zip ANDERSON SC 29625
Yes No

M-128728

Driver/Pedestrian's Full Name

CORDELL DOUGLAS E

Unit # 02 Sex M Race W Street [REDACTED]
Birth Date [REDACTED] City, State, & Zip WILLIAMSTON SC 29697
State SC Driver's License # [REDACTED] Insurance Company: NATIONWIDE
Year 1996 4S Body Vehicle Make TOYT VIN # JT3GP10V9T [REDACTED]
State SC Year 2016 License Plate # [REDACTED] Owner's D.L. # UNKNOWN
Home Telephone [REDACTED] Owner's Full Name CORDELL BARBARA KAY
Bus. Telephone [REDACTED] Street [REDACTED]
Contributed To Collision City, State, & Zip WILLIAMSTON SC 29697
Yes No

Driver/Pedestrian's Full Name

State Year License Plate # Owner's D.L. #

Unit # Sex Race Street
Birth Date City, State, & Zip
State Driver's License # Insurance Company:
Year Body Vehicle Make VIN #
Home Telephone Owner's Full Name
Bus. Telephone Street
Contributed To Collision City, State, & Zip
Yes No

All Units Insurance Information
(to be completed by Investigating Officer)

Accident Insurance Information for Unit # 01
Company Name SC BUDGET & CONTROL Area Code/Phone Number (800) 7132205
Agency Name Policy Number [REDACTED]
Accident Insurance Information for Unit # 02
Company Name NATIONWIDE Area Code/Phone Number (800) 4213535
Agency Name Policy Number [REDACTED]

Automobile Liability Insurance Information

Notice of Requirement Accepted Signature Y N Refused to Affix Signature?
Y N Vehicle Subject to Registration in SC?
To Be Completed Below or Entered at WWW.SC-ALIR.COM By Insurance Company representative. This form should not be mailed to DMV if insurance information has been submitted electronically.
Reference to Unit #: I hereby affirm that to the best of my knowledge the vehicle described above was insured by the below stated insurance company on the date of the collision.
Insurance Company Policy # Signature Title
Beginning Date: Ending Date: Policy Holder: Vehicle Insured by SC Department of Motor Vehicles Bus. Telephone ()

Notice: If liability insurance was not in effect for your vehicle involved in the collision, the Department of Motor Vehicles could suspend your driver license and registration privileges pursuant to South Carolina Code of Laws 56-9-351 and 56-10-530.

If any of the below are applicable, Disregard the above portion.

Form FR-10 Not Issued: Section 56-10-520

Check here if a Form SR-23, Fleet policy of 25 or more vehicles is on file with the Department of Motor Vehicles covering the vehicle
Check here if a Certificate of self-insurance has been issued by the Department of Motor Vehicles covering the vehicle and indicate the certificate number: SI-
Check here if liability insurance was not in effect to comply with South Carolina statutory requirements
Investigating Officer's Name: STONE - W A Date: T682 Date: HP03 Date: [REDACTED]
Signature: [REDACTED] Signature: [REDACTED]
For operating or allowing the operation of an uninsured vehicle
Summons Issued to: Summons Number: [REDACTED]
Internal Agency Use: 16GV051508

ACDSNB

TRANSPORTATION VEHICLE ACCIDENT REPORT FORM

The information provided on this ACDSNB Transportation Vehicle Accident Report Form will be used to compile accurate, uniform, and reliable information about Agency vehicle (van, bus, small vehicle, and multi-function bus) accidents so that problems and trends may be identified and needed safety programs can be developed.

Complete and turn in this form to Transportation Dept. within two (2) business days of the accident if it involved a ACDSNB vehicle, or:

- > \$2,500 or more of total property damage, or
- > Personal injury (requiring treatment away from the scene), and/or fatality, to any involved vehicle occupant or pedestrian.

This form must be completed by the operator involved in the accident, or operator supervisor, and any staff passengers. **A supervisor must review and sign the completed form.** Enter only one response for each question.

Accident

Description I was turning off of Webb road, to my left was an 18 wheeler truck, which was turning right onto Webb road (but was at a complete stop) and then another car was behind it... Nothing else was coming either way, so I proceed to go, I'm out turning left, then the car that was behind the 18 wheeler apparently comes flying from behind it and hit me!!!

1. Driver Name Jessica Jenkins

2. Date of Accident 3/14/16 3. Day of week Monday 4. Time 10:59
☒ AM ☐ PM

5. Vehicle Body Make Chey VN 6. Bus/vehicle # 444

7. Vehicle Type: Small Vehicle ☒ Bus ☐ Lift Van ☐ Van ☐ Lift Bus ☐

8. Model Year 2004 9. Vehicle Capacity _____

10. Department Name HASCI

11. Was the Operator? a. ☒ Route Operator b. ☐ Activity Trip Operator c. ☐ OTHER

12. Operator's Age:

a. ☒ 21-30 b. ☐ 31-40 c. ☐ 41-50 d. ☐ 51-60 e. ☐ 61-70 f. ☐ 71 +

13. Operator's Experience Driving Agency Vehicle:

a. ☒ less than 1 year b. ☐ 1-4 Years c. ☐ 5-9 years d. ☐ 10-14 Years e. ☐ 15-19 Years f. ☐ 20 + Years

14. In the last 3 years, how many Agency vehicle accidents has the operator had? (do not include this accident) 0

15. Agency Vehicle Use at Time of Accident:

a. ☒ Route b. ☐ Other (Specify)

16. Total Number of Consumers in vehicle: 2 Any Injuries 0

17. First Point of Impact (please circle appropriate letters)

F - Front

R - Rear

DS - Driver Side

PS - Passenger Side

18. Type of Accident:

a. ☒ Between Vehicles b. ☐ Fixed Object (complete #19) c. ☐ RR Crossing (with train) d. ☐ Overturn
e. ☐ Pedestrian f. ☐ Animal

19. Complete if Fixed Object Accident
(enter response which caused damage):

a. ☐ Parked Vehicle b. ☐ Utility Pole c. ☐ Tree d. ☐ Culvert or Wall e. ☐ Sign f. ☐ Guardrail
g. ☐ Bridge Rail h. ☐ Fence i. ☐ Curb or Wall j. ☐ Median Barrier k. ☐ Embankment l. ☐
Other _____ (Specify)

20. Were Passengers Evacuated? a. ☐ Yes b. ☒ No

21. Were Any Passengers Secured By? a. ☐ Wheelchair b. ☒ ^{Seatbelt.} Lapbelt c. ☐ Not Secured

22. First Person notified of accident? 911/Supervisor

23. Was Pre-Trip inspection of vehicle performed by driver on date of accident? a. ☒ Yes b. ☐ No

24. Are there any actions driver feels could have prevented accident? (explain)

I could have just sat there until Nothing at all was on the road.

Driver Signature _____

Date 3/15/11

Supervisor Signature _____

Date _____

Transportation Signature _____

Date _____

ACDSNB

TRANSPORTATION VEHICLE ACCIDENT REPORT FORM

The information provided on this ACDSNB Transportation Vehicle Accident Report Form will be used to compile accurate, uniform, and reliable information about Agency vehicle (van, bus, small vehicle, and multi-function bus) accidents so that problems and trends may be identified and needed safety programs can be developed.

Complete and turn in this form to Transportation Dept. within two (2) business days of the accident if it involved a ACDSNB vehicle, or:

- > \$2,500 or more of total property damage, or
- > Personal injury (requiring treatment away from the scene), and/or fatality, to any involved vehicle occupant or pedestrian.

This form must be completed by the operator involved in the accident, or operator supervisor, and any staff passengers. **A supervisor must review and sign the completed form.** Enter only one response for each question.

Accident

Description I LOOKED BOTH WAYS SEVERAL TIMES BEFORE TURNING LEFT FROM
OLD ASBURY RD, ONTO WHITEHALL RD AND WAS STRUCK BY THE GAS TANK ON THE
DRIVER SIDE OF THE VAN, THE GUY ON THE MOTORCYCLE PUT ON HIS BRAKES AND
STELL STOPPED INTO THE VAN CAUSING SUBSTANTIAL DAMAGE TO DRIVERS SIDE OF THE
VAN, I COULD SEE NOTHING OR ANYONE UPON ENTERING ROAD AND WHEN THE VAN GOT
HEAT.

1. Driver Name OBERIL MARRIN

2. Date of Accident 7/16/16 3. Day of week SATURDAY 4. Time 1021
☒ AM ☐ PM

5. Vehicle Body Make FORD 6. Bus/vehicle # 684

7. Vehicle Type: Small Vehicle ☐ Bus ☐ Lift Van ☐ Van ☒ Lift Bus ☐

8. Model Year _____ 9. Vehicle Capacity 15

10. Department Name RESIDENTIAL

11. Was the Operator? a. ☐ Route Operator b. ☐ Activity Trip Operator c. ☒ OTHER

12. Operator's Age:

a. ☐ 21-30 b. ☐ 31-40 c. ☒ 41-50 d. ☐ 51-60 e. ☐ 61-70 f. ☐ 71 +

13. Operator's Experience Driving Agency Vehicle:

a. ☐ Less than 1 year b. ☐ 1-4 Years c. ☐ 5-9 years d. ☐ 10-14 Years e. ☐ 15-19 Years f. ☐ 20 + Years

14. In the last 3 years, how many Agency vehicle accidents has the operator had? (do not include this accident) 0

15. Agency Vehicle Use at Time of Accident:

a. ☒ Route b. ☐ Other (Specify) _____

16. Total Number of Consumers in vehicle: 2 Any Injuries 0

17. First Point of Impact (please circle appropriate letters)

F - Front

R - Rear

DS - Driver Side

PS - Passenger Side

18. Type of Accident:

a. ☒ Between Vehicles b. ☐ Fixed Object (complete #19) c. ☐ RR Crossing (with train) d. ☐ Overturn
e. ☐ Pedestrian f. ☐ Animal

19. Complete if Fixed Object Accident

(enter response which caused damage):

a. ☐ Parked Vehicle b. ☐ Utility Pole c. ☐ Tree d. ☐ Culvert or Wall e. ☐ Sign f. ☐ Guardrail
g. ☐ Bridge Rail h. ☐ Fence i. ☐ Curb or Wall j. ☐ Median Barrier k. ☐ Embankment l. ☐
Other _____ (Specify)

20. Were Passengers Evacuated? a. ☐ Yes b. ☒ No

21. Were Any Passengers Secured By? a. ☐ Wheelchair b. ☐ Lapbelt c. ☐ Not Secured

22. First Person notified of accident? ANTHONY EDWARDS

23. Was Pre-Trip inspection of vehicle performed by driver on date of accident? a. ☒ Yes b. ☐ No

24. Are there any actions driver feels could have prevented accident? (explain)

THE PERSON DRIVING MOTORCYCLE SAW ME AND WAS SPEEDING CAUSING THE ACCIDENT.
ON MY PART I LOOKED BOTH WAYS SEVERAL TIMES SEEING NOTHING

Driver Signature _____

Date 7/16/16

Supervisor Signature _____

Date _____

Transportation Signature _____

Date _____

8-22-ESTIMATE
\$ 4386-25

Dennis Roosevelt Mallory

DOB [REDACTED]

SS# [REDACTED]

Floyd Hall

DOB [REDACTED]

SS# [REDACTED]

Mail FR-10 to: SC Department of Motor Vehicles Office of Financial Responsibility (203-894-5000) PO Box 455, Southwood, SC 29686-0455				SOUTH CAROLINA DEPARTMENT OF MOTOR VEHICLES FR-10 REV 11/2011 NOTICE OF REQUIREMENT				System - Electronically. Agents or Company Representatives can submit your Insurance Information at: www.SC-AIR.COM			
Date	Time	City/State	County	Collision Location (Rt = Name)	Station	Rate	Class	Dir.	In		
07-16-2016	1030	04	Anderson	34 / WHITEHALL RD	Anderson	4.27	Anderson	Anderson	Anderson		
To Vehicle Owner/Operator: Failure to return this form to the Department of Motor Vehicles within 15 days from the date of the collision could result in the suspension of your driver license and registration privileges pursuant to South Carolina Code of Laws 56-9-351 and 56-10-530.											
M-238254 Driver's Full Name: DYAR CHRISTOPHER B					M-238255 Driver's Full Name: MARINA DEREK DERE						
Unit	Sex	Race	Street	City, State, & Zip	Unit	Sex	Race	Street	City, State, & Zip		
01	M	W		ANDERSON SC 29621	02	M	B		ANDERSON SC 29621		
1					2						
State	Year	Body	Vehicle Make	Year	State	Year	Body	Vehicle Make	Year		
SC	2003	MC	HD	2011	SC	2011	VN	FORD	2011		
State	Year	License Plate	Owner's DL	State	Year	License Plate	Owner's DL				
SC		NONE		SC		RG22571	NONE				
Home Telephone: [Redacted] Owner's Full Name: DYAR CHRISTOPHER B					Home Telephone: [Redacted] Owner's Full Name: MARINA DEREK DERE						
Business Telephone: [Redacted]					Business Telephone: [Redacted]						
Contributed To Collision: Yes					Contributed To Collision: Yes						
City, State, & Zip: ANDERSON SC 29621					City, State, & Zip: ANDERSON SC 29625						
Driver's Full Name: [Redacted]											
Unit	Sex	Race	Street	City, State, & Zip	Unit	Sex	Race	Street	City, State, & Zip		
01					02						
1					2						
State	Year	Body	Vehicle Make	Year	State	Year	Body	Vehicle Make	Year		
SC					SC						
All Units Insurance Information (to be completed by Investigating Officer)											
Accident Insurance Information for Unit # 01 Company Name: DAIRYLAND INS CO Agency Name: [Redacted]					Accident Insurance Information for Unit # 02 Company Name: AMERICAN SOUTHERN INS CO Agency Name: [Redacted]						
Automobile Liability Insurance Information											
Notice of Requirement Accepted					Signature: [Redacted]						
To be Completed Before or After: If insurance information has been submitted electronically, the information is considered to be a representation of the above insurance company and no warranty of liability is implied into the above mentioned insurance policy.											
Insurance Company: [Redacted]					Signature: [Redacted]						
Beginning Date: [Redacted]					Ending Date: [Redacted]						
Notice: If liability insurance was not in effect for your vehicle involved in the collision, the Department of Motor Vehicles could suspend your driver license and registration privileges pursuant to South Carolina Code of Laws 56-9-351 and 56-10-530.											
If any of the below are applicable, Disregard the above portion.											
Check Here if a Form FR-23, Fleet Policy of 25 or more vehicles is on file with the Department of Motor Vehicles covering the vehicle.					Form FR-10 Not Issued: Section 56-10-520						
Check Here if a certificate of self-insurance has been issued by the Department of Motor Vehicles covering the vehicle and no certificate number is.					If FR-10 issued to Operator, Owner of Unit:						
Check Here if liability insurance was not in effect to comply with South Carolina statutory requirements.					Summons issued to:						
Signature: [Redacted]					Signature: [Redacted]						
Date: [Redacted]					Date: [Redacted]						
Investigating Officer's Name: STANDARD - J E					Investigating Officer's Name: [Redacted]						
Rate: TFC					Rate: [Redacted]						
Bureau: T619					Bureau: [Redacted]						
Code: HP03					Code: [Redacted]						
Date: [Redacted]					Date: [Redacted]						
Ref: [Redacted]					Ref: [Redacted]						
Internal Agency Code: 16GV143177					Internal Agency Code: [Redacted]						

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Mail FR-10 to: SC Department of Motor Vehicles Office of Financial Responsibility (203) 856-5000 PO Box 495 Sylva, SC 29686-0495				SOUTH CAROLINA DEPARTMENT OF MOTOR VEHICLES REV. 11-2017 NOTICE OF REQUIREMENT				Submit Electronically: Agents or Company Representatives can submit your insurance information at: MySC-AUR.COM			
Date	Time	County	1- Interstate 2- Secondary 3- Primary 4- County 5- State	Collision Location (Rte & Name)		2-A Interstate 3- State	4-1	City	State	Zip	
10-21-2016	1430	04		US 29 / E SHOCKLEY FERRY R				ANDERSON	SC	29624	
To Vehicle Owner/Operator: Failure to return this form to the Department of Motor Vehicles within 15 days from the date of the collision could result in the suspension of your driver license and registration privileges pursuant to South Carolina Code of Laws 56-9-351 and 56-10-530.											
R-008438				R-008439				R-008439			
Driver's Full Name: BARBARA JEAN HOLDEN				Driver's Full Name: SMITH WAYNE HARRIS				Driver's Full Name: SMITH WAYNE HARRIS			
Unit: 01, Sex: F, Race: B, Street: [REDACTED]				Unit: 02, Sex: M, Race: W, Street: [REDACTED]				Unit: 01, Sex: M, Race: W, Street: [REDACTED]			
City, State, & Zip: [REDACTED] SC 29678				City, State, & Zip: [REDACTED] SC 29624				City, State, & Zip: [REDACTED] SC 29624			
State: SC				State: SC				State: SC			
Year: 2016, Body: BU, Vehicle Make: FORD, VIN: 1F0EE3FL8GDC03548				Year: 1998, Body: 4S, Vehicle Make: FORD, VIN: 2FAFP73W9W [REDACTED]				Year: 2016, Body: [REDACTED], Vehicle Make: [REDACTED], VIN: [REDACTED]			
State: SC, Year: 2009, License Plate: RGL1581, Owner's DL: NONE				State: SC, Year: 2016, License Plate: [REDACTED], Owner's DL: [REDACTED]				State: SC, Year: 2016, License Plate: [REDACTED], Owner's DL: [REDACTED]			
Home Telephone: [REDACTED], Business Telephone: [REDACTED]				Home Telephone: [REDACTED], Business Telephone: [REDACTED]				Home Telephone: [REDACTED], Business Telephone: [REDACTED]			
Contributed To Collision: Yes				Contributed To Collision: No				Contributed To Collision: No			
City, State, & Zip: ANDERSON SC 29624				City, State, & Zip: ANDERSON SC 29624				City, State, & Zip: ANDERSON SC 29624			
All Units Insurance Information (to be completed by Investigating Officer)											
Accident Insurance Information for Unit: 01											
Company Name: AMERICAN SOUTHERN INS, Area Code/Phone Number: 800/7132205											
Accident Insurance Information for Unit: 02											
Company Name: NATIONWIDE, Area Code/Phone Number: 1864/2609272											
Automobile Liability Insurance Information											
Notice of Requirement Accepted											
To Be Completed Before or Entered at MySC-AUR.COM by Insurance Company Representative. If information is not submitted electronically, please mail to DMV. If insurance information has been submitted electronically, please refer to Unit: [REDACTED]. Hereby affirm that to the best of my knowledge the vehicle described above was insured by the listed insurance company on the date of the collision.											
Insurance Company: [REDACTED], Policy #: [REDACTED]											
Beginning Date: [REDACTED], Ending Date: [REDACTED], Policy Holder: [REDACTED]											
Notice: If liability insurance was not in effect for your vehicle involved in the collision, the Department of Motor Vehicles could suspend your driver license and registration privileges pursuant to South Carolina Code of Laws 56-9-351 and 56-10-530.											
If any of the below are applicable, Disregard the above portion.											
One of the following Form 2025, Electronic or Paper, was filed with the Department of Motor Vehicles covering the vehicle.											
One of the following Certificate of Self-Insurance has been issued by the Department of Motor Vehicles covering the vehicle and no date of certificate number 21.											
One of the following Certificate of Insurance was not in effect to comply with South Carolina statutory requirements.											
Form FR-10 Not Issued: Section 56-10-520											
If FR-10 issued to Operator, Date of Unit: [REDACTED]											
Summons issued to: [REDACTED]											
For operating or allowing the operation of an uninsured vehicle											
Summons Number: [REDACTED]											
Investigating Officer Name: STANDARD - J E, Title: TFC, Supv: T619, Code: HP03, Date: [REDACTED], Signature: [REDACTED]											
Printed Agency Code: 16GV208528											

ACDSNB

TRANSPORTATION VEHICLE ACCIDENT REPORT FORM

The information provided on this ACDSNB Transportation Vehicle Accident Report Form will be used to compile accurate, uniform, and reliable information about Agency vehicle (van, bus, small vehicle, and multi-function bus) accidents so that problems and trends may be identified and needed safety programs can be developed.

Complete and turn in this form to Transportation Dept. within two (2) business days of the accident if it involved a ACDSNB vehicle, or:

- \$2,500 or more of total property damage, or
- Personal injury (requiring treatment away from the scene), and/or fatality, to any involved vehicle occupant or pedestrian.

This form must be completed by the operator involved in the accident, or operator supervisor, and any staff passengers. **A supervisor must review and sign the completed form.** Enter only one response for each question.

Accident

Description At the intersection of McQuiff St. my light was green, I was going through the light when a car went through his light and hit the back side of the bus.

1. Driver Name Barbara Holden
2. Date of Accident 10/21/2016 3. Day of week Friday 4. Time 2:39
☐ AM ☐ PM
5. Vehicle Body Make _____ 6. Bus/vehicle # 548
7. Vehicle Type: Small Vehicle ☐ Bus ☒ Lift Van ☐ Van ☐ Lift Bus ☐
8. Model Year 2015 9. Vehicle Capacity 15
10. Department Name Electrolux Enclave
11. Was the Operator? a. ☒ Route Operator b. ☐ Activity Trip Operator c. ☐ OTHER
12. Operator's Age:
a. ☐ 21-30 b. ☐ 31-40 c. ☐ 41-50 d. ☐ 51-60 e. ☒ 61-70 f. ☐ 71 +
13. Operator's Experience Driving Agency Vehicle:
a. ☐ less than 1 year b. ☐ 1-4 Years c. ☐ 5-9 years d. ☒ 10-14 Years e. ☐ 15-19 Years f. ☐ 20 + Years
14. In the last 3 years, how many Agency vehicle accidents has the operator had?
(do not include this accident) 0

15. Agency Vehicle Use at Time of Accident:

a. ☒ Route b. ☐ Other (Specify) _____

16. Total Number of Consumers in vehicle: 3 Any Injuries 0

17. First Point of Impact (please circle appropriate letters)

F - Front

R - Rear

DS - Driver Side

PS - Passenger Side

18. Type of Accident:

a. ☒ Between Vehicles b. ☐ Fixed Object (complete #19) c. ☐ RR Crossing (with train) d. ☐ Overturn
e. ☐ Pedestrian f. ☐ Animal

19. Complete if Fixed Object Accident

(enter response which caused damage):

a. ☐ Parked Vehicle b. ☐ Utility Pole c. ☐ Tree d. ☐ Culvert or Wall e. ☐ Sign f. ☐ Guardrail
g. ☐ Bridge Rail h. ☐ Fence i. ☐ Curb or Wall j. ☐ Median Barrier k. ☐ Embankment l. ☐
Other _____ (Specify)

20. Were Passengers Evacuated? a. ☒ Yes b. ☐ No

21. Were Any Passengers Secured By? a. ☐ Wheelchair b. ☒ Lapbelt c. ☐ Not Secured

22. First Person notified of accident? HUP, Transportation

23. Was Pre-Trip inspection of vehicle performed by driver on date of accident? a. ☐ Yes b. ☒ No

24. Are there any actions driver feels could have prevented accident? (explain)

Continue to look both ways even if light
is green?

Driver Signature _____

Date 10/24/2018

Supervisor Signature _____

Date _____

Transportation Signature _____

Date _____

Passengers

(John) Randall King -
Marla Helms -
Keisha Hardy -